CHILD DEVELOPMENT SERVICES
MILITARY MEDICAL CONSENT AUTHORIZATION

(TO BE USED FOR MILITARY FAMILY MEMBERS ONLY)

Instructions: Fill out all spaces. If an item is not applicable, put "N/A" in the space. This form is a legal document and must be filled out completely and correctly to be valid. *NO CORRECTIONS ARE ACCEPTABLE!*

To: Health Services Clinic,

I, _____, am the parent or lawful guardian of the child named below, and entitled to medical care at your facility.

Full Name: _____ Age: _____

Address: _____ Phone: _____

_____ ID Card # _____

_____ Exp. Date _____

_____ _____ _____

(Sponsor's name) (SSN) (Duty station)

_____

OPFAC (if known)

I _____ appoint the Director in Charge of the Child Development Center to be my lawful Attorney-in-fact (agent) for the purpose specified herein.

I also appoint:

_____

(Name) (Phone number)

_____

(Signature) (Date)

_____

(Address) (Relationship)

to act as my Attorney-in-Fact and to perform, or consent to performance of, any and all acts that I might perform or give my consent to be performed, if I were present, for the following purpose.

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The person(s) named above may authorize any medical or surgical procedures or treatments deemed necessary by the staff of the _____ Medical Clinic or any duly licensed medical practitioner for the health and well being of my child(ren) aforementioned. I understand that the staff of the _____ _____ Medical Clinic include, in addition to Physicians and Dentists, Health Service Technicians and Physicians Assistants who function under the supervision of a Physician and that these staff members may be called to evaluate and/or treat my child(ren).

I give this authorization in advance of any medical care or treatment in order to provide my Attorney-in-Fact the specific authority to consent to said care or treatment.

I understand that this authorization is valid only for the person(s) named herein and that it may be in force for up to one year. It is to take effect on _____, _____ and terminate on _____, ____.

Witnessed: Date: _____

The person signing this form is known to me to be the parent/legal guardian of the above named child(ren).

_____

(Signature of witness) (Printed name)

Approval Date: _____

_____

Chief, Medical Administration Branch
Health Services Division

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